DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

DASG-HCO (870)

15 Oct 92

MEMORANDUM FOR DIRECTOR, MILITARY SUPPORT, HEADQUARTERS, DEPARTMENT OF THE ARMY, WASHINGTON, DC 20310

SUBJECT: Hurricane Support Operations After Action Report

1. This is the medical after action report and observations from the FY92 Hurricane operations in Florida, Louisiana, Guam and Hawaii. Each functional and geographical area is addressed separately in this report. There was no DoD medical support provided to Louisiana nor Guam, thus, there is no mention of such throughout this report.

2. This report is structured by medical functional areas: command and control, mission, concept of operations, task organization, personnel, hospitalization, evacuation, patient administration, mental health, veterinary services, National Disaster Medical System (DMATS), Veterans Administration and preventive medicine. A chronology of events is at enclosure 4 and Observations/Lessons Learned are at Encl 8.

3. The Department of Army was designated as the DoD Executive Agent for disaster relief in Florida, Louisiana, Guam and Hawaii.

a. CINCFOR was the supported CINC for Florida and Louisiana. CINCFOR divided relief responsibilities into two geographic regions. CDR, 2d CONSUSA had responsibility for Florida, 5th CONSUSA had responsibility for Louisiana. The Commander, 44th Medical Brigade served as the JTF-Andrew Surgeon and ARFOR Surgeon in Florida.

b. CINCPAC was the supported CINC of Guam and Hawaii disasters. CDR, CINCPAC divided relief responsibilities into two regions with PACOM overseeing Guam while USARPAC had responsibility for Hawaii. Joint Task Forces were established under the command and control of the respective areas.

c. In Florida, the JTF-ANDREW Surgeon deployed on 28 Aug 92. The major task was determining the extent of damage and operational capability of the civilian health care systems. This was a joint effort with DoD, FEMA, PHS and NDMS. CAPT Gray, Public Health Services had <u>overall</u> medical jurisdiction.

4. Mission. The medical mission was to provide basic medical support on an area basis to civilian communities in conjunction with disaster relief operations until the civilian healthcare infrastructure had been re-established at pre-disaster levels of health support.

5. Concept of Operations.

a. The medical concept of operations was to provide primary and secondary healthcare and medical surveillance within the disaster area (Encl 1) and to establish the traditional field/tailgate medicine. Early in the operation, traditional means of support had to be tailored to fit the environment. Medics and evacuation vehicles were dispersed individually throughout the civilian neighborhoods to take the support to the people. This was necessary because most of the people did not have means of transportation nor did they want to leave their possessions unguarded. Medic patrols were developed placing the medic on the street or at key road intersections. Other facilities were erected at points where medical facilities previously existed, in the thought that civilians would drift to those "last known" sites in search for medical care. Additionally, the locations of medical sites were continuously broadcasted over the Armed Forces Radio Network or published in local leaflets.

b. DoD Phases of operation were:

PHASE I. RELIEF
- Basic Needs
- Public Health
- Public Works

PHASE II. RECOVERY
- Debris Removal
- Damage Assessment
- Government Facilities

PHASE III. RECONSTITUTION
- Government Facilities
- Public Health
- Homes

c. The medical operations were conducted in three phases congruent with the DoD phases.

(1) PHASE 1: Relief operations - to provide

immediate life support and to assess the health and medical needs within each community.

(2) PHASE 2: Recovery Operations - to sustain services provided in Phase 1; to assist and advise state and local agencies and re-establishing pre-disaster levels of health services support.

(3) PHASE 3: Reconstitution - transition of HSS to state and local agencies with release documentation. (Medical Concept of Operations, see encl 1 medical planning guidance.)

6. Task Organization.

a. The Task Organization was truly dependent on the current situation and needs of the communities based upon the amount of destroyed medical facilities.

b. From the time of the Presidential order to deploy Federal troops into Southern Florida the DoD active duty medical task organization was completed within 11 days. Time delays were due to only to the opening of and the capabilities of an airport in the disaster area.

c. In Florida the medical Task Organization, (encl 2) consisted of:

-3 Hospitals, a 40 Bed CSH, a 20 bed Marine Clearing Company and a 14 bed Air Force Air Transportable Hospital.
-1 Area Support Medical Battalion.
-2 Dispensaries.
-6 Preventive Medicine Detachments.
-2 Veterinary Detachments.
-1 Mental Health Team (Navy).
-1 Medical Logistics Forward Distribution team.
-2 Aeromedical Evacuation Aircraft (UH-60).
-2 Command and Control Headquarters.
-6 Divisional Forward Support Medical Companies.
-9 Battalion Aid Stations.
-1 Problem Definition Assessment Team.

d. In Hawaii, the medical task organization was in place within 2 days after Hurricane Iniki struck. The task organization consisted of:

-1 Divisional Forward Support Medical Company
-1 Aeromedical Evacuation aircraft (UH-1)
-5 Battalion Aid Stations
-1 Marine Battalion Aid Station

e. Six Liaison Officers from HQDA and Health Services Command were deployed to establish liaison between JTF-A, NDSM and HQDA. They were Psychiatric, Operations, Logistics, Veterinarians (2) and Health Facility Planning. The Liaison Officer from DASG-HCO deployed with a INMARSAT telephone and Laptop with modem capability. This provided a direct communications link from the LNO to OTSG. No liaison officers were dispatched to USARPAC, Hawaii.

7. Personnel.

a. HQDA (DAPE-MO) transmitted a message on personnel and administrative guidance for voluntary order of USAR personnel to active duty in support of disaster relief operations associated with Hurricane Andrew. There is a requirement for USAR personnel being called to active duty who have not had an HIV screen performed within the last six months to be screened if they are on active duty for more than 31 consecutive days. An Individual who has not had a screen 6 months prior to active duty must have an HIV screen performed with results prior to the 31st day of active duty. OTSG reviewed this policy for the feasibility to waive this requirement as to not delay support operations. The requirement was not waived and the HIV screening was coordinated through FORSCOM and performed by the FORSCOM HIV Coordinator at the Martinez Reserve Center in Perrine, FL.

b. A total of 77 Medical Professional Filler (PROFIS) personnel from 22 separate installations were deployed. The system worked efficiently and effectively. Cross leveling between installation occurred providing backfills to Ft Bragg or Ft Drum as those installations deployed their PROFIS from their MEDDAC's. See Encl 3.

c. With the Presidential order activating the Stafford Act, DoD could legally treat civilians. The Office of The Surgeon General, Quality Assurance Division, processed the health care provider licensure requirement to the State of Florida as an additional means of legality coverage.

8. Hospitalization.

a. In Florida, the 44th Medical Brigade, 1st COSCOM

deployed a 40 bed tailored Combat Support Hospital (CSH). The CSH established 12 operating beds. On 2 separate days, 13-14 Sep, patient census exceeded that capacity with a census of 16 and 14 beds occupied, respectively.

b. There were no Corps hospitals deployed to Hawaii. Hospitalization was provided by local civilian hospitals.

9. Aeromedical Evacuation.

a. Florida. The 57th Medical Detachment self deployed with 2 UH-60's. The unit flew a total of 11 patients (7 military/4 civilians).

b. Hawaii. The 68th Medical Detachment initially self deployed to Kauai with 2 aircraft the day after the hurricane. On Day 3, the unit redeployed one aircraft to Ohau.

10. Patient Administration. Patient accounting (workload reporting) did not begin until 7 Sep. However, DoD assets were treating patients as early as 4 Sep. JTF-A had responsibility to account for patients treated. As of 10 Oct 92, 13,388 military and 48,902 civilian patients were treated in Florida and in Hawaii 761 military and 258 civilians were treated. See Encl 4.

11. Medical Logistics.

a. Florida. Medical supply was originally tasked to the Veterans Administration in Miami. As the volume of medical supply donations increased, the 32d MEDSOM accepted joint mission in the warehousing, control and distribution of supplies. Coordination was effected to locate and make known to all agencies the locations of disaster relief sites for the purpose of delivery of materials and retrieval of excess materials to the needs of the site. The MEDSOM worked closely with the Public Health service and the State Pharmacy Task Force. See Encl 5.

b. Hawaii. Medical logistics was provided from Tripler Army Medical Center.

12. Mental Health.

a. Divisional mental health assets are capable of conducting psychiatric triage, crisis intervention and 72 hour holding capability. A Special Psychiatric Rapid Intervention Team (SPRINT), U.S. Navy deployed to Florida to assist the Divisional units in the mental health mission.

b. The critical mission in both states was to conduct an health intelligence estimate of the area. This enabled the force planners to develop deployment flow and type of mental health units/specialties required. This also enabled the medical providers to develop treatment plans. Essential elements of information were developed, disseminated and surveys were conducted. As a result of these surveys the planners were able to designated geographical "hot spots" and position teams/ units in those areas.

c. A 24 hour crisis service was established in Florida and received a total of 12 calls over a 11 day period. Only 4 of these 12 calls were classified as emergencies.

d. A Disaster Medical Assistance Team (DMAT), mental health team from Hawaii, deployed to Florida and later redeployed to Hawaii in support of both operations.

13. Veterinary Services.

a. Two veterinary units deployed to Southern Florida to perform three major missions.

(1) The food inspection mission included supporting Class 1 supply points, mobile field kitchens and on call support to civilian relief agencies.

(2) The animal medicine mission included coordinating care for stray and injured animals, providing direct care in emergencies and continuous care for injured horses at the Tropical Park.

(3) The area assessment mission included evaluating the rabies and other zoonotic disease threats and evaluating the condition of the civilian practices in the affected area.

14. Disaster Medical Assistance Teams (DMATS).

a. Florida. FEMA deployed a total of 16 DMATs phased over the 4 week period. The controlling factor of the DMATS are that they can only serve a total of 14 days on duty. This allows the personnel to return to their business or place of employment with out disruption to their businesses/services. A Management Support Unit (MSU) deployed as the DMAT Command and Control Headquarters. Patient census for these agencies totaled 17,290 as of 24 Sep 92.

b. Hawaii. FEMA deployed 6 DMATs to Hawaii, phased over a 5 week period. Patient census is unavailable.

15. Veterans Administration. The Veterans Administration deployed 3 mobile clinic vans from Prescott, N.M., Fayetteville, N.C., and Spokane, Wa. to Florida. These vans were used for 11 days (31 Aug - 10 Sep) and treated a total of 4,308 patients.

16. Preventive Medicine.

a. Preventive Medicine was the greatest medical problem in the disaster area. A total of 6 preventive medicine teams were deployed into the disaster area. Major efforts were directed towards personal and food sanitation, control of vectors, education and potable water supplies.

b. An epidemiological survey was conducted in Florida. The epidemiologic surveillance data reveals there were no major outbreaks of diseases which is attributed to the public emphasis on safety, sanitary and water discipline. Common gastrointestinal disease level stayed at 5 percent of the population treated for illness. Two major areas studied were dermatologic and minor wounds averaging 15 percent of the treated population. See Encl 6.

7 Encls
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STEVEN M. LEMON
Major, MS
Operations and Plans
Action Officer

ML NUMBER - 237 0751/04SEP92 BY AF9FORJ6-C
CO: NCE ANDREW CLASSIFIED SIZ AT FORCE
FROM: SEE BELOW

TO: SEE BELOW

CLASS: UNCLASSIFIED

SUBJECT: MEDICAL PLANNING GUIDE

RATUZYUU 2472300-UUUU--
ZNR UUUUU
R 032300Z SEP 92
FM CINCFOR FT MCPHERSON GA//FCJ3-CAT//
TO CDRJTF ANDREW MIAMI INT AP MIAMI FL
CDRXVIII ABN CORPS FUD HOMESTEAD AFB//FZA-GT//
CDRXVIII ABN CORPS FT BRAGG NC//ATZA-GT//
INFO CDRUSAHSC FT SAM HOUSTON TX//HSOP-SO/HSPE-MO/HSCL-A//
USCINCCENT MCDILL AFB FL
USCINCLANT NORFOLK VA//J33/J522//
USCINCTRANS SCOTT AFB IL//TCT3/TCJ5-DW//
BT
UNCLAS//
OPER/HURRICANE RESPONSE/CINCFOR/HURRICANE ANDREW//
MSGID/GENADMIN/FORSCOM-SURG//
SUBJ/MEDICAL PLANNING GUIDANCE//
REF/A/ORDER/FORSCOM FCJ3-CAT/242300ZAUG92/ANDR-1//
AMPN/EXECUTE ORDER - HURRICANE ANDREW RESPONES//
REF/B/ORDER/FORSCOM FCJ3-OC/291145ZAUG92//
AMPN/FRAG ORDER 8 - JTF SERVICE COMPONENTS AUGMENTEES//
REF/C/SITREP/FORSCOM FCJ3-OC/020001ZSEP92//
AMPN/SITREP 0009//
POC/KELLER/MAJ/PRIPHN:DSN 367-7682/-/FT MCPHERSON GA//
RMKS/1. THE FOLLOWING SERVES TO REITERATE GENERAL PLANNING GUIDANCE FOR THE JTF COMMANDER FOR MEDICAL SUPPORT IN CATASTROPHIC DISASTER RELIEF OPERATIONS. IT IS APPLICABLE TO ALL DOD FORCES AND INSTALLATIONS TASKED BY CINCFOR IN SUPPORT OF FEDERAL, STATE, AND LOCAL EMERGENCY SUPPORT OPERATIONS.
2. PROVIDE FOR THE MEDICAL REQUIREMENTS OF DOD FORCES EMPLOYED IN SUPPORTING DISASTER RELIEF OPERATIONS. PROVIDE DIRECT SUPPORT TO STATE AND LOCAL AGENCIES WHEN THEIR RESOURCES ARE OVERWHELMED AND MEDICAL AND/OR PUBLIC HEALTH ASSISTANCE IS REQUESTED.
3. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IS THE PRIMARY LEAD AGENCY FOR EMERGENCY SUPPORT FUNCTION (ESF) NO. 8 (HEALTH AND HUMAN SERVICES) AND PROVIDES FEDERAL ASSISTANCE TO STATE AND LOCAL RESOURCES IN RESPONSE TO PUBLIC HEALTH AND MEDICAL CARE NEEDS. DOD HAS SECONDARY SUPPORT RESPONSIBILITY FOR ESF 8. ASSISTANCE WILL BE FURNISHED WHEN STATE AND LOCAL RESOURCES ARE OVERWHELMED AND MEDICAL

Encl 1

GOVERNMENT.
4. THE JTF SURGEON HAS RESPONSIBILITY FOR TECHNICAL DIRECTION AND SUPERVISION OF ALL DOD MEDICAL RESOURCES IN CJTF AOR. DHHS HAS RESPONSIBILITY TO COORDINATE OVERALL MEDICAL SUPPORT.
5. THE DHHS REPRESENTATIVE IS RESPONSIBLE TO THE FEDERAL COORDINATING OFFICER (FCO) FOR ESF NO. 8 ADMINISTRATION. FOR NEEDS BEYOND THE STATE AND LOCAL RESOURCES, DHHS CAN REQUEST ASSETS FROM THROUGHOUT THE UNITED STATES. INCLUDING DOD. ALL REQUESTS FOR ASSISTANCE MUST BE COORDINATED THROUGH THE DEFENSE COORDINATING OFFICER (DCO) AND THE FEDERAL COORDINATING OFFICER (FCO).
6. FEDERAL MEDICAL RESPONSE EFFORTS WILL CONTINUE UNTIL THE DISASTER SCENE NO LONGER REQUIRES FEDERAL MEDICAL ASSISTANCE AND A DECISION IS MADE BY FEMA, ON THE RECOMMENDATION OF DHHS TO CEASE RESPONSE OPERATIONS. MILITARY UNITS WILL EITHER RETURN TO THEIR HOME STATIONS OR BE ASSIGNED ADDITIONAL MISSIONS AS THE SITUATION DICTATES. AT NO TIME WILL MILITARY MEDICAL UNITS BE REASSIGNED OR RETURNED HOME WITHOUT DIRECT AUTHORITY FROM THE CJTF.
7. MILITARY MEDICAL ASSISTANCE MADE AVAILABLE TO CIVIL AUTHORITIES WILL BE TEMPORARY IN NATURE AND TERMINATE AS SOON AS POSSIBLE IN ORDER TO CONSERVE MILITARY RESOURCES AND TO AVOID INFRINGEMENTS ON THE RESPONSIBILITY AND AUTHORITY OF CIVIL GOVERNMENT AGENCIES.
8. OTHER CONSIDERATIONS. MEDICAL SUPPORT MAY INCLUDE PROVIDING DENTAL TREATMENT FOR EMERGENCY REQUIREMENTS, VETERINARY CARE, MEDICAL LOGISTICS AND PREVENTIVE MEDICINE.
9. FORWARD ALL PERTINENT MEDICAL REPORTS AND SPECIFIC REQUIREMENTS THROUGH THE JTF SURGEON AND INCLUDE IN THE JTF DAILY SITREP.
10. THERE ARE JOINT MEDICAL PLANNERS REPRESENTING ALL SERVICES AT THE VARIOUS CONUSAS WHO ARE TRAINED AND FAMILIAR IN DEALING WITH THE VARIOUS LOCAL AND NATIONAL CIVILIAN COORDINATING AGENCIES. JTF SURGEON CAN REQUEST ADDITIONAL JTF PERSONNEL RESOURCES FROM CINCFOR.
11. CINCFOR SUPPORTED CINC. ALL SUPPORTING CINCS AND THEIR COMPONENTS (AFFOR, NAVFOR (CTF 28) AND MARFOR (II MEF)) MEDICAL FORCES ARE SUPPORTING. ALL COMPONENT FORCES AND SUPPORTING CINCS BE PREPARED, ON ORDER, TO PROVIDE CINCFOR, THROUGH THE JTF SURGEON, WITH SPECIFIC INFORMATION AS REQUIRED.
12. CJTF HAS OPCON OF ALL DOD MEDICAL FORCES SUPPORTING HURRICANE RELIEF OPERATIONS IN AOR.//
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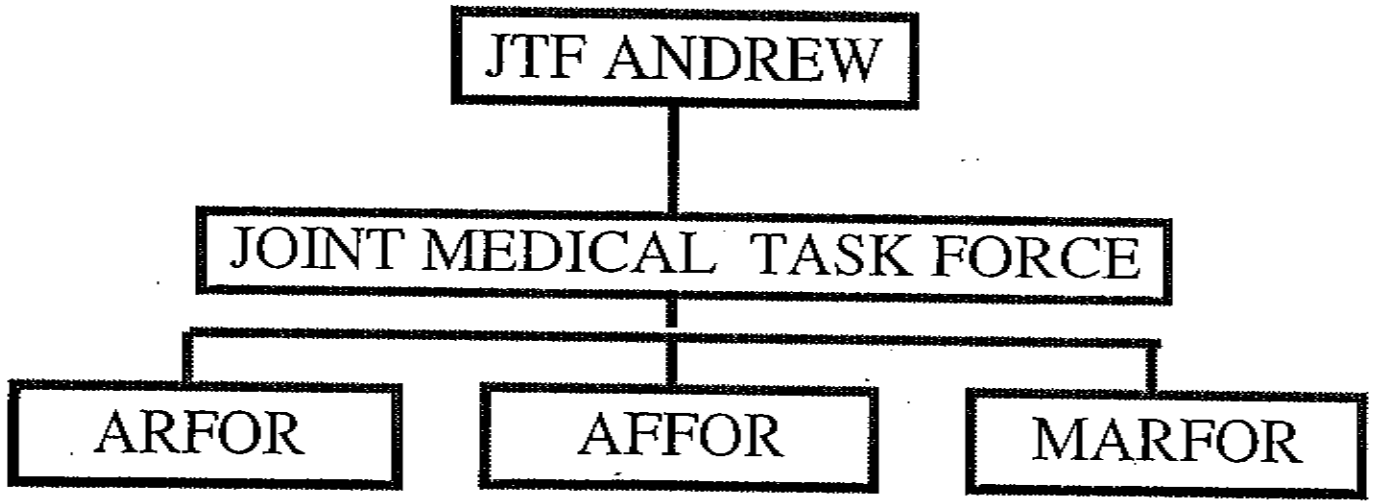
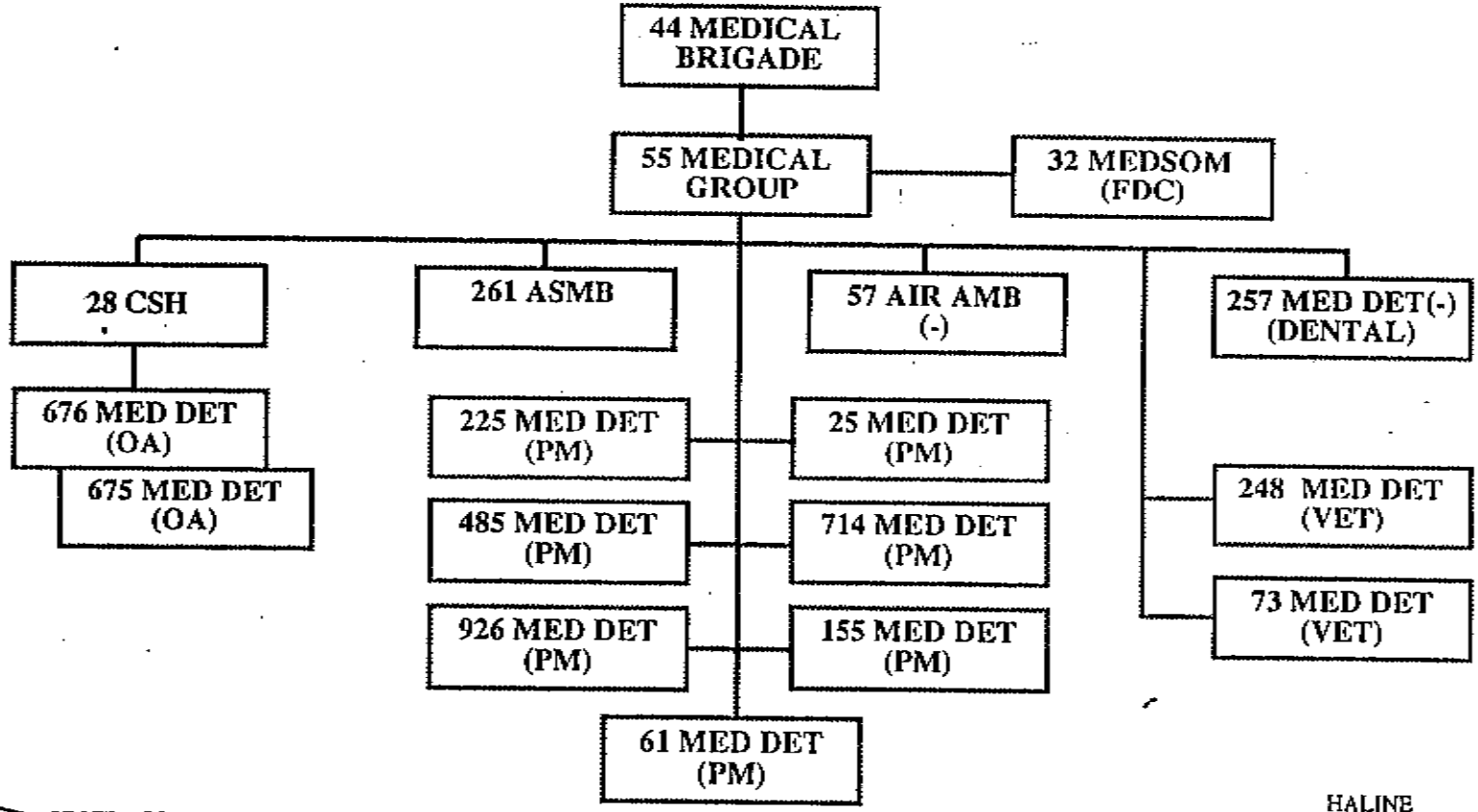
Encl 1

HURRICANE OPERATIONS



HURRICANE OPERATIONS

JTF ANDREW MEDICAL



JOINT TASKFORCE ANDREW
MEDICAL TASKFORCE

DEPLOYMENTS

- 77 HSC Personnel Deployed

MC	DC	VC	AN	MS	WO	CH	EM
36	9	1	11	5	2	4	9

- 46 PROFIS Deployed

MC	DC	AN	MS	WO
32	7	2	3	2

DASG-PTM 15SEP92

JOINT TASKFORCE ANDREW

HSC DEPLOYMENTS

LOSING INSTAL	MC	DC	VC	AN	MS	WO	CH	EM	TOTAL
BAMC	1								1
EAMC	3								3
FAMC							1	1	2
MAMC							1		1
TAMC	4								4
WRAMC	2						2	2	6
Ft Belvoir	1								1
Ft Benning	2					1		1	4
Ft Bliss				1					1
Ft Bragg	13	7		8	3	1			32
Ft Campbell								1	1
Ft Carson	1								1
Ft Drum	7	2						1	10
Ft Hood	1								1
Ft Jackson								1	1
Ft Meade				1					1
Ft MCClellan			1					1	2
Ft Polk					1				1
Ft Rucker				1					1
Ft Sill	1								1
AMEDD C&S					1			1	2
TOTAL	36	9	1	11	5	2	4	9	77

DASG-PTM 16SEP92

JOINT TASKFORCE ANDREW
MEDICAL TASKFORCE

HSC CROSSLEVELING

FROM:	TO: FT BRAGG	FT DRUM
BAMC	1 62A (ER Phy)	
FAMC	1 60P (Peds)	
WRAMC	1 60N (Anesth)	
FT BELVOIR		1 61H
FT BENNING	1 61H (Fam Prac)	
FT CAMPBELL	1 61H	
FT JACKSON	1 61H	1 62B (Fld Surg)
FT POLK		1 62B
FT RILEY		1 61H
FT SILL		1 61H
LARMC	2 66H (Md Sur Nur)	
FT ORD	2 66H	
TOTAL	10	5

DASG-PTM 15SEP92

HURRICANE RELIEF MEDICAL TASKFORCE

DEPLOYMENTS

- 10 HSC Personnel Deployed

MC	MS	WO	EM
7	1	1	1

- 8 PROFIS Deployed

MC	MS
7	1

DASG-PTM 131100OCT92

HURRICANE RELIEF
HSC DEPLOYMENTS

LOSING INSTAL	MC	MS	WO	EM	TOTAL
EAMC	1				1
MAMC	1				1
TAMC	3				3
Ft Benning	1		1	1	3
Ft Drum	1'				1
Ft Polk		1			1
TOTAL	7	1	1	1	10

DASG-PTM 131100OCT92

MEDICAL CHRONOLOGY

DATE	EVENT
24 Aug	-Hurricane Andrew strikes Southern Florida. -2 Disaster Medical Assistance Teams alerted to deploy. -2031 FLARNG on active duty.
25 Aug	-2 DMATs arrive and operate from the Opa Locke Airport.
26 Aug	-Hurricane Andrew strikes Louisiana -2 pallets of Class VIII from DDEAMC, Ft Gordon arrive in Opa Locka for DMAT resupply. -3 DMATS alerted for LA. -First active component alerted - Engineer Prime Power unit. The 156th Medical Company, FLARNG activated. -Eisenhower Medical Center request for supplies from 2nd Army Senior Medical Advisor. Approximately one 463L pallet load of supplies was provided.
27 Aug	-LAARNG activated 1083 soldiers. -3 DAMTs alerted for LA are stood down. -President of the United States directs DOD intervention. -A 20 bed Marine/Navy Clearing Company is alerted for Florida. -1st COSCOM, 44th MED BDE begins deployment plans.
28 Aug	-LOC opened. Initial coordination with LOC, USAMMA and the Medical Group. -55th Medical Group identified requirement for an International Maritime Satellite (INMARSAT) to replace a non-mission capable (NMC) INMARSAT. -Operational INMARSAT delivered from Tobyhanna Army Depot, by courier, on 29 Aug 92. The NMC INMARSAT was returned to Tobyhanna for repair.
29 Aug	-55th Medical Group requested issue of five, water test kit, reverse osmosis, for deployment with 714th PM Det, 1 Sep 92. Requirement passed to USAMMA. USAMMA passed requirement to DPSC for procurement.
30 Aug	-Assisted AOC in collection of data and preparation of briefing for CSA. Requested stock status from USAMMA for Gamma-Globulin, Tetanus Diphtheria, surgical scrub brushes and Sharps containers.
31 Aug	-Water test kits procured and shipped to Ft. Bragg.

DATE	EVENT
	-Advised that CSA wanted all Army health care providers to wear brassards.
1 Sep	-32nd Medical Logistics Battalion (MEDLOG BN) determined sufficient stocks of medical brassards were on hand. Shipped to Florida. -Assisted AOC in preparation of Information Paper, Subject: Class VIII Medical Resupply, for presentation to CSA.
2 Sep	-LTC Touchton to Florida to assist 44th Medical Brigade. -10th Inf Div closes. -PDA team arrives.
3 Sep	-Briefed Mr. Ron Richards, DOD-HA (Readiness) on on-going log support. -910 Airlift Wing receives tasker for mosquito spray.
4 Sep	-44th Medical Brigade (Fwd) requested assignment of a DODAAC for the 32nd MEDLOG BN (Fwd) forward distribution team. -225 Medical Detachment arrives. -28 CSH relocates to James Arthur Smith. -First HSS RAG report rec'd from 44th Medical Brigade, all areas are amber. -A veterinary Task Force is formed to work on the stray animal control.
5 Sep	-All functional areas are amber except Preventive Medicine 485th (Sanitation) and 926th (Ento) Medical Detachments (PM) arrive completing the medical task organization.
6 Sep	-All functional areas remain amber except Preventive Medicine which is Red. -Navy Sprint Team is requested. -Patients treated to date are 609 military and 5558 civilians.
7 Sep	-Treated 779 military and 7720 civilian
8 Sep	-Navy Sprint team (Mental Health) arrives. -Treated 1113 military and 11555 civilians. -Requested information from AMC rep in LOC on procedure for obtaining DODAAC.
9 Sep	-Navy sprint reports for duty treated 2237 military and 18007 civilians. -No change in HSS RAG status.

DATE	EVENT
10 Sep	-Emergency Medical Services/Evacuation is close to reporting GREEN on the HSS RAG report while others remain unchanged. -Treated 2942 military and 23735 civilians. -Developed Decision Points and strategy for transition of medical services to the civilian sector. -911 working.
11 Sep	-Hurricane Iniki strikes Kauai, Hawaii -4 DMATS on alert for Hawaii. -Patients treated: 3979 military and 29477 civilian. -Florida HSS RAG report has significant changes as the first factional area to go GREEN is Dental and Hospitalization and Veterinary services are in between Amber and Green. -Research of Army Regulations revealed units desiring assignment of an additional DODAAC must request from their installation coordinator. This information was passed to 44th Medical Brigade HQ, Ft. Bragg for action. -MAJ Shelton, USAMMA, deployed to 44th Medical Brigade AOR.
12 Sep	-Dade County has resumed the water sampling mission. -Patients treated: 5255 military and 31171 civilians. -EMS has attained pre-disaster capability, however, the HSS RAG report still reflects in between Amber and Green. Functional areas are Green: Dental; between Amber and Green: Evacuation, Hospitalization, Veterinary services and Mental Health; Amber: treatment, Preventive Medicine, Medical Logistics, C2 and communications.
13 Sep	-LTC Touchton returned from disaster area. -Advised by AOC that there were no medical logistics support issues for Hurricane Iniki. -Treated 5843 military and 33252 civilians. -FEMA has procured double wide trailers to operate health clinics.
14 Sep	-No change to HSS RAG report. -Dental and Emergency Medical Services go GREEN. -Patients treated: 6371 military and 35,660 civilians. -Hawaii -2 UH-1 self deployed to Kauai. -Tripler Army Medical Center deploys 6 PROFIS.
15 Sep	-Three functional areas are Green on the HSS RAG report are Evacuation, hospitalization and dental. -Patients treated: 6920 military and 38662 civilians.

DATE	EVENT
	-Health Facility Planners assessment of facilities is complete. -Beginning to develop a TPFDL.
16 Sep	-VA Demobilizes 2 of the 3 mobile clinics operating in Florida. -Only 3 DMATS remain in Florida. -Patients treated: 7450 military and 40,195 civilians. -HSS RAG Report reflect GREEN: Evac, hospitalization and dental; between green and Amber are: Preventive Medicine, veterinary, mental health and C2.
17 Sep	-Patients treated: 8235 military and 40564 civilians. -No Change to HSS RAG report
18 Sep	-Patients treated: 8684 military and 41,728 civilians. -No Change to HSS RAG report.
19 Sep	-No Changes to HSS RAG report. -Patients treated: 9125 military and 42,892 civilians.
20 Sep	-No Change to HSS RAG report. -Patients treated: 9280 military and 43,846 civilians in Florida, 167 military and 102 civilians in Hawaii.
21 Sep	-HSS RAG report reflects the following ratings: -GREEN: Evac, Hospitalization, Preventive Medicine, Dental and mental Health. GREEN/AMBER: Treatment, Veterinary, Medical Logistics, C2 and Communication. -Patients treated: 9433 military and 44,482 civilians, 210 military and 130 civilians. -Homestead civilian Hospital assume operational - control of Homestead area relieving Military of the responsibility.
22 Sep	-Patients treated: 9749 military and 45,643 civilians in Florida, 294 military and 158 civilians in Hawaii.
23 Sep	-Patients treated: 10,234 military and 45,804 civilians in Florida, 319 military and 176 civilians in Hawaii.
24 Sep	-Patients treated: 10722 military and 46,138 civilians in Florida, 383 military and 202 civilians in Hawaii

DATE	EVENT
25 Sep	-32nd MED LOG BN relinquished control of donated supplies to Florida's Human Rehabilitative Services and returned to Ft. Bragg. Medical supply requirements for the 10th Mountain Division were satisfied by the DVA. -Patients treated: 11240 military and 47,178 civilians in Florida, 439 military and 218 civilians in Hawaii.
26 Sep	-Patients treated: 11,662 military and 48,076 civilians in Florida, 509 military and 232 in Hawaii.

HURRICANE OPERATIONS

CLASS VIII REQUESTS

	# REQNS	FILL	D/0	CA
ARMY	3636	3450	77	109
USMC	104	104	0	0
VA/CIVILIAN	2037	1919	0	118
TOTAL	5777	5473	77	277

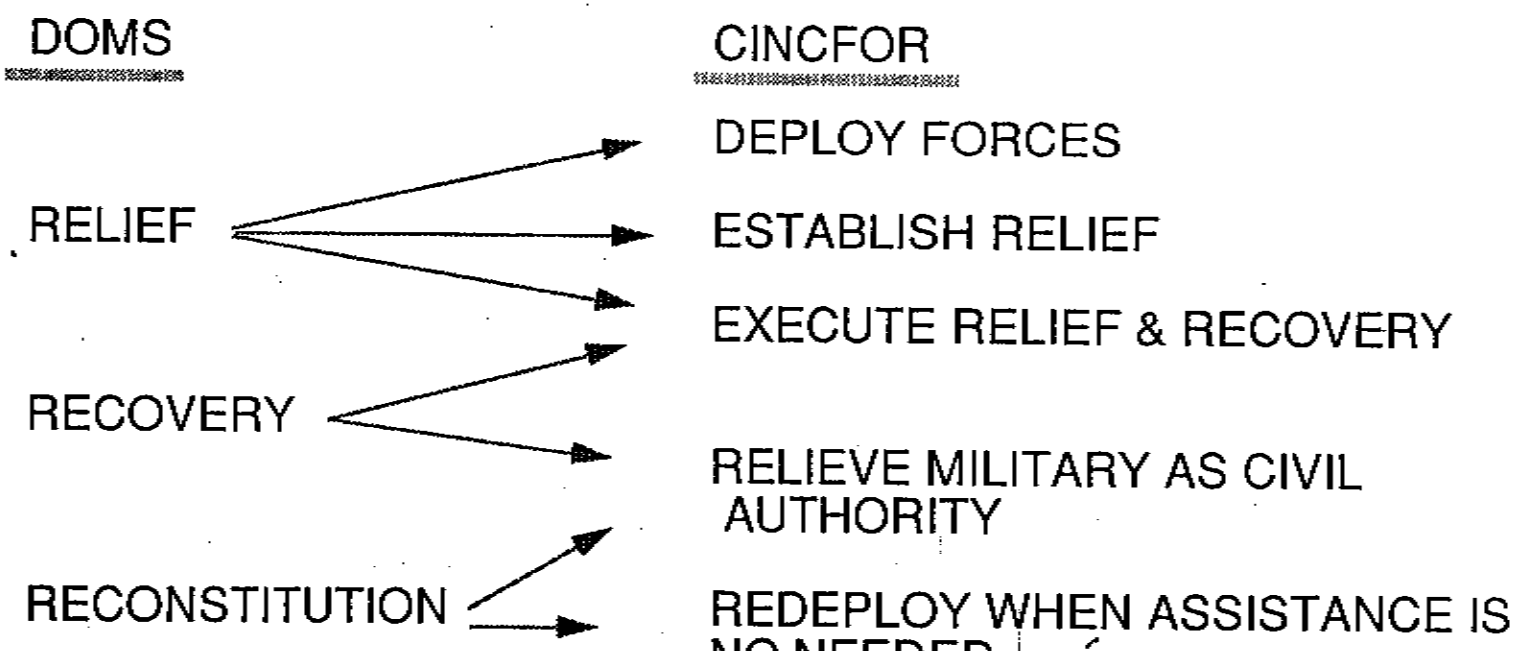
RECEIVED AND PROCESSED 125 TONS

DISTRIBUTED 25 TONS

Encl 5

HURRICANE OPERATIONS

CONCEPT OF OPERATIONS



HURRICANE OPERATIONS

JTF ANDREW MEDICAL SUPPORT

MISSION:

PROVIDE BASIC MEDICAL SUPPORT ON AN AERA BASIS TO CIVILIAN COMMUNITIES IN CONJUNCTION WITH DISASTER RELIEF OPERATIONS UNTIL THE CIVILIAN HEALTHCARE INFRASTRUCTURE HAS BEEN REESTABLISHED AND PREDISASTER LEVELS OF HEALTH SUPPORT IS AVAILABLE.

CONCEPT:

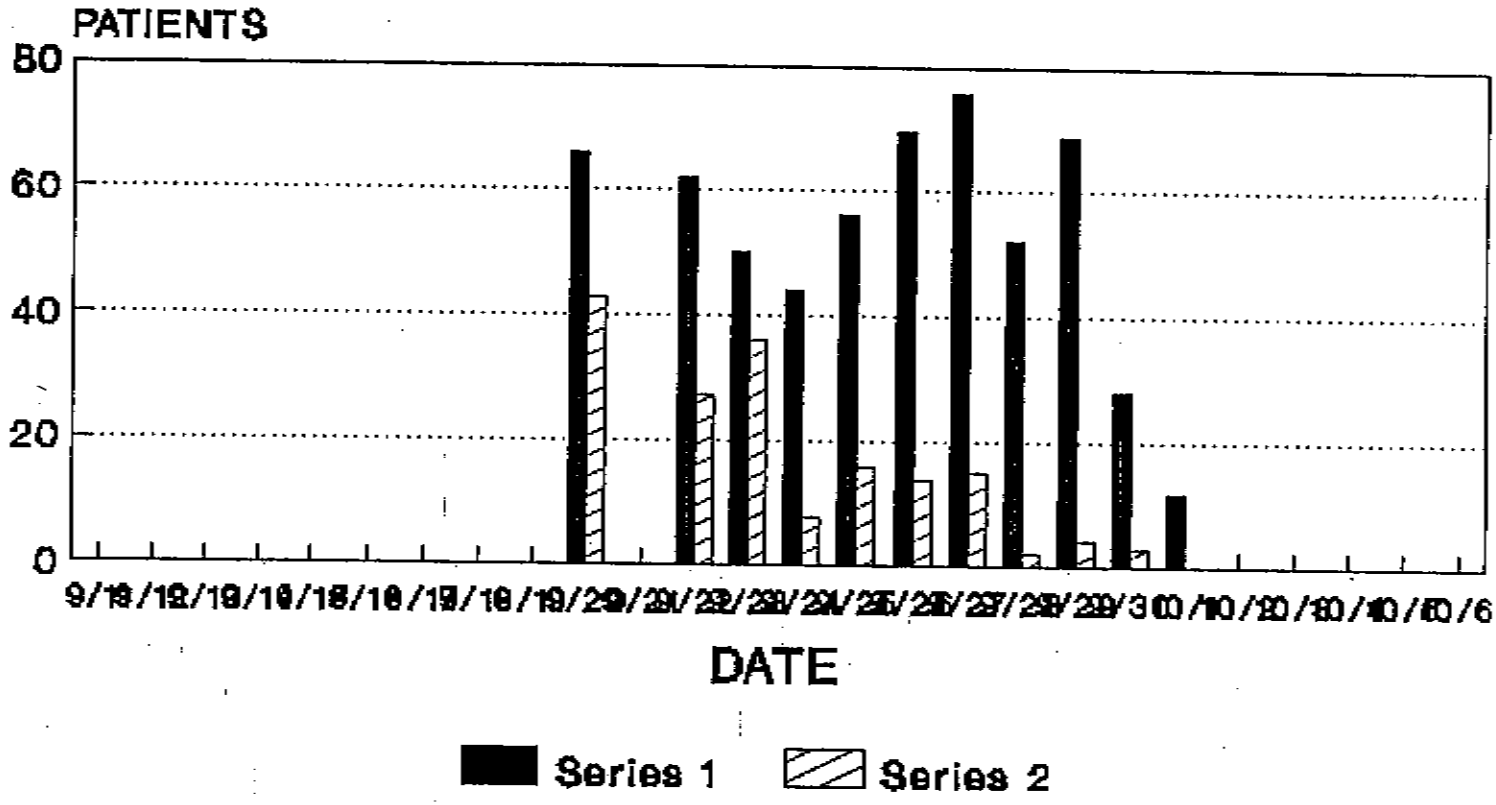
UNIFORMED MEDICAL SERVICES, IN CONJUNCTION WITH LOCAL, STATE, AND FEDERAL MEDICAL RESOURCES, PROVIDE PRIMARY AND SECONDARY HEALTHCARE AND MEDICAL SURVEILLANCE WITHIN THE FEDERALLY DECLARED DISASTER AREA.

HURRICANE OPERATIONS

JTF MEDICAL METL

- JTF SURGEON AND DOD MEDICAL COORDINATOR
- TAILGATE MEDICINE
- MEDICAL SURVEILLANCE
- ESTABLISH MEDICAL SUPPORT SITES
- SINGLE POINT OF CONTACT FOR MEDICAL LOGISTICS
- PROVIDE MEDICAL SUPPORT TO ARFOR
- BE PREPARED TO AUGMENT CIVILIAN HOSPITALS

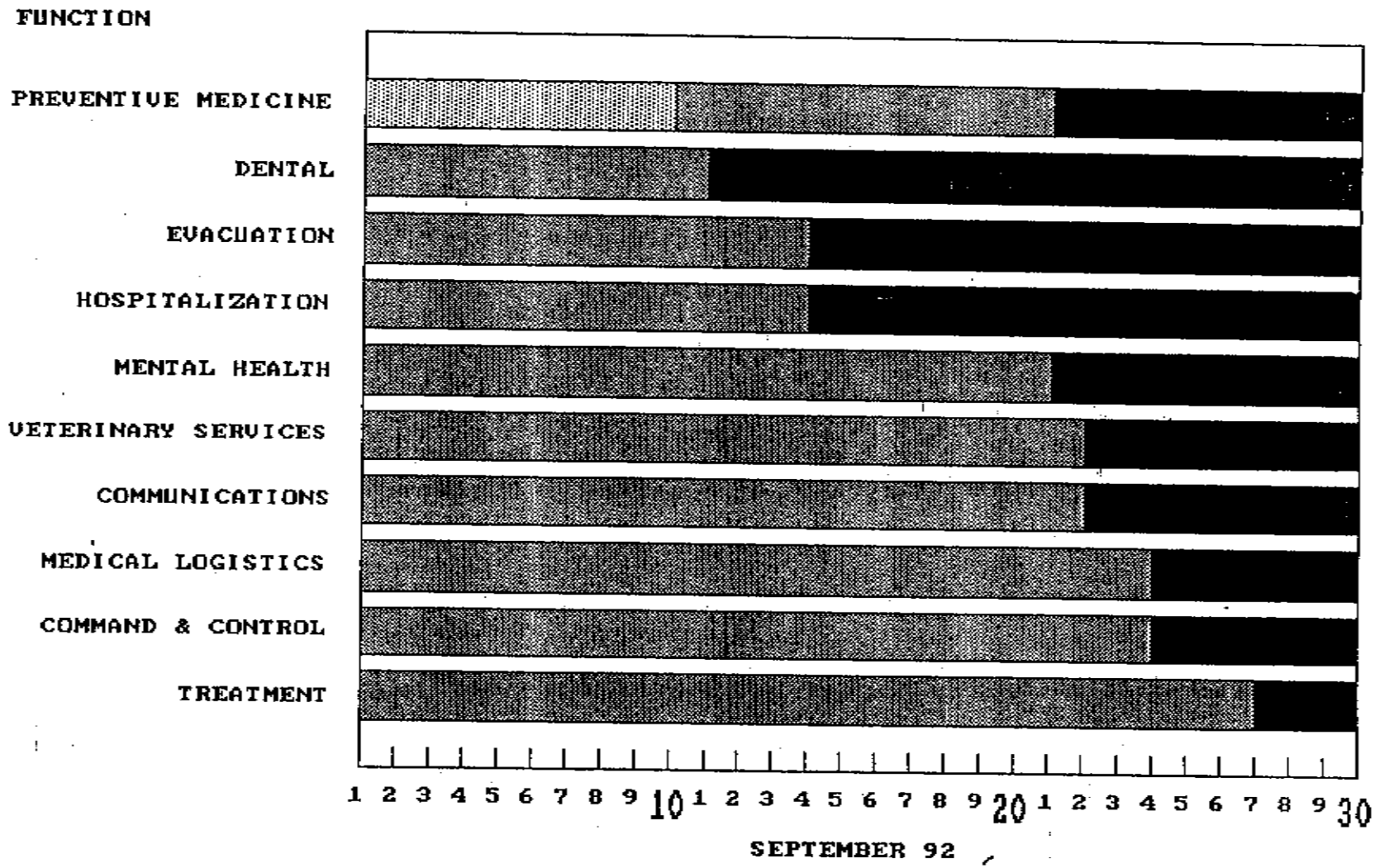
HAWAII PATIENT CENSUS
DOD ASSETS

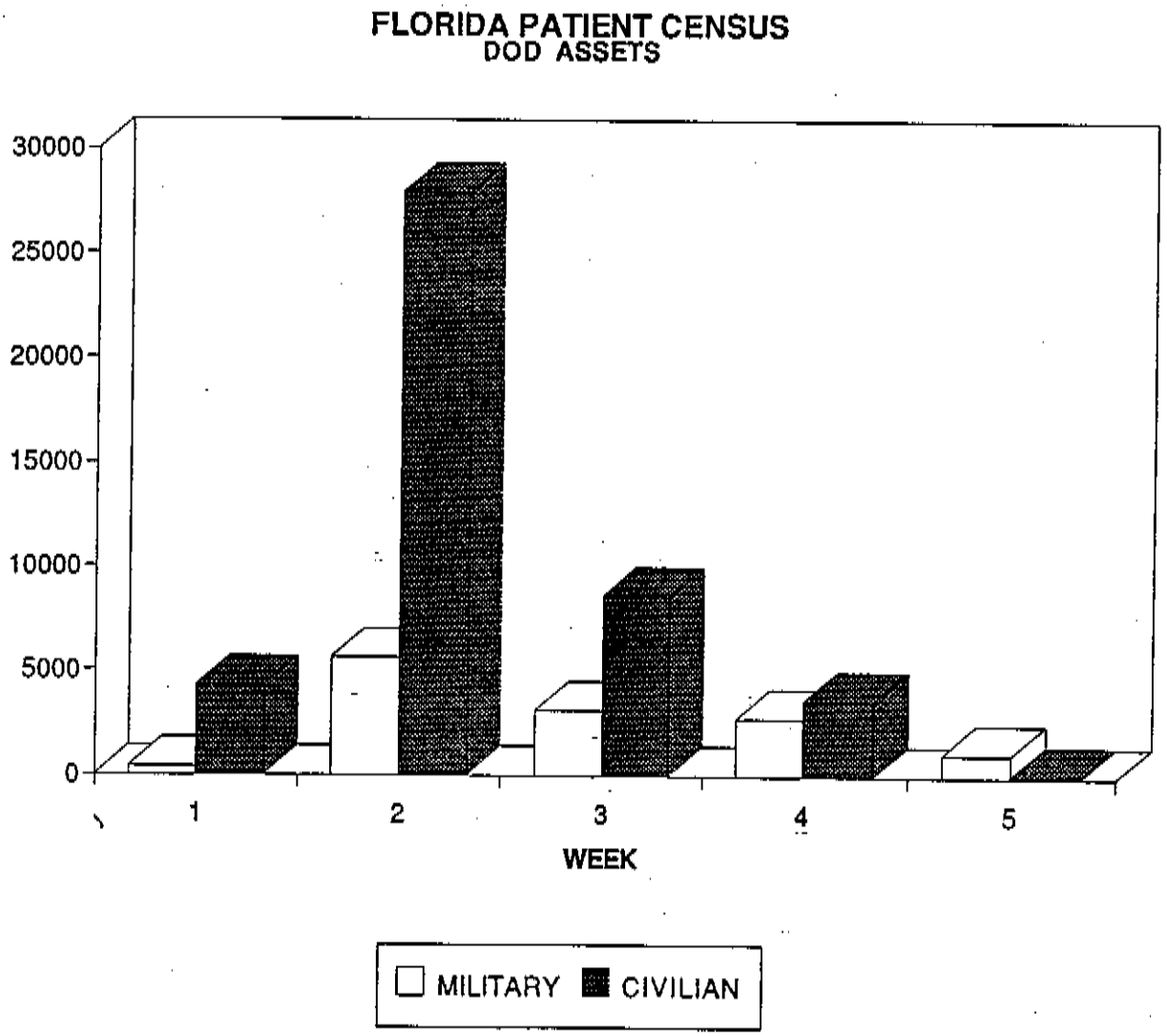


HURRICANE HIT HAWAII 11 SEP 93
SERIES 1 = MILITARY
SERIES 2 = CIVILIANS

HPG

FUNCTIONAL AREA ASSESSMENT - FLORIDA




FLORIDA PATIENT CENSUS
DOD ASSETS
30000
25000
20000
15000
10000
5000
0
1
2
3
4
5
WEEK
MILITARY
CIVILIAN

HURRICANE OPERATIONS

TOTAL PATIENTS TREATED

MILITARY PATIENTS	13,333
CIVILIAN PATIENTS	48,901

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH CARE OPERATIONS

OBSERVATION: Disaster relief planning and implementation. Given that major hurricanes--and other natural disasters--will continue to negatively impact lives and properties within the United States and that the DOD may assume a greater role in future disaster relief operations. Disaster planning must be proactive and reality-based.

DISCUSSION: While it is apparent that considerable federal planning for medical operations was conducted prior to Hurricane Andrew, the plans proved ineffective in resolving actual emergency medical needs. Basically, the numbers and type of players involved in the relief operations far exceeded the planned for coordination requirements and thus the implementation capabilities of the disaster relief management team. Planning is fundamentally important, however, plans which cannot be effectively implemented are useless.

RECOMMENDATION: In order to adequately address future disater relief needs the DOD must immediately undertake proactive, reality-based planning activities. These adverse activities must encompass not only planning for the coordination and utilization of known federal (FEMA, DOD, USPHS, Veterans Administration and other federal agencies), state and local assets, but planning in anticipation of the massive relief efforts conducted by civilian volunteer agencies, formal and ad hoc organizations (Red Cross, NDMS-DMATs, pharmaceutical companies, health care delivery management groups, medical equipment companies and religious civic groups) and individual volunteers. Furthermore, these planning activities must be targeted at resolving the complete spectrum of short and long term disaster relief needs: From emergency trauma care to extensive public health interventions to reconstructing the medical facility infrastructure. Critical to developing realistic disaster plans is the need to identify a central authority for managing implementation. While the team approach enhances comprehensive planning, in order to efficiently implement those plans there must be a central authority capable of expediting relief response activities in a time-sensitive and typically chaotic environment. The HFAA refief unit should be integral to any team conducting disaster planning and augment the central authority by providing management and action capabilities during implementation.

POC: MAJ Lemon, DASG-HCO, 756-8186.

Epidemiologic Disease Surveillance Data

30 Aug - 5 Sept 92, 4654 MTF visits

Diagnostic Category	Total	30 Aug-3 Sept	4 Sept	5 Sept
1. Minor Wounds	16%	20%	15%	10%
2. Dermatologic	15%	13%	17%	14%
3. Orthopedic Inj.	7%	6%	7%	6%
4. Respiratory	7%	6%	8%	7%
5. Gastrointestinal	6%	4%	4%	13%
(Diarrhea constitutes 30% of all gastrointestinal illnesses)				
6. Dental	2%	2%	1.3%	1.4%
7. Heat Inj.	1.6% (73)	3% (51)	0.8% (11)	0.8% (11)
(Soldiers constitute 21 of 73 reported heat injuries)				
8. Burn Inj.	1.3% (60)	2% (35)	1.1% (16)	0.7% (9)
9. Psychiatry	0.9% (42)	2% (33)	0.3% (5)	0.3% (4)
10. Animal Bites	0.2% (11)	<1% (7)	0.1% (2)	0.1% (2)
11. Immunizations	14% (664)	23% (442)	9% (139)	7% (83)

Epidemiologic Disease Surveillance Data
5 - 12 Sept 92
Military MTFs (12,719 visits for 8/30-9/12)
28 Reporting Nodes

No. Visits Monitored	976	936	1258	1538	1039	1183	875
Diagnostic Category	9/6	9/7	9/8	9/9	9/10	9/11	9/12
1. Minor Wounds	16%	17%	14%	15%	11%	14%	15%
2. Dermatologic	13%	14%	14%	10%	13%	12%	10%
3. Orthopedic Inj.	8%	10%	8%	7%	10%	10%	11%
4. Respiratory	12%	10%	10%	8%	11%	9%	11%
5. Gastrointestinal	5%	5%	5%	5%	5%	5%	5%
(Diarrhea constitutes 31% of cases, 12 of 39 GI cases on 9/12)							
6. Dental	1.0%	3%	3%	4%	5%	3%	3%
7. Heat Inj. (No.)	1.4% (14)	1.2% (11)	2.5% (31)	1.0% (16)	0.8% (8)	0.7% (8)	0.5% (4)
8. Burn Inj. (No.)	0.5% (5)	0.9% (8)	1.0% (12)	0.8% (11)	0.8% (8)	1.0% (12)	1.3% (12)
9. Psychiatry (No.)	0.3% (3)	0.5% (5)	0.6% (7)	0.5% (7)	0.8% (8)	0.2% (2)	0.2% (2)
10. Animal Bites (No.)	0.6% (6)	0.5% (5)	0.3% (4)	0.5% (7)	0.2% (2)	0.3% (4)	0.1% (1)
11. Immunizations (No.)	11% (106)	9% (84)	8% (103)	6.1% (94)	11% (111)	6.3% (75)	6.6% (58)

Trends:
- GI rate continues steady at 5%, no clustering of cases
- One lightning-associated injuries on a FI ARNG
- Low number of heat injuries continues to decrease, more emphasis by safety folks & water discipline

Epidemiologic Disease Surveillance Data
14 - 20 Sept 92
Civilian MTFs Monitored by DHRS

Diagnostic Category	9/14	9/15	9/16	9/17	9/18	9/19	9/20
1. Respiratory Illnesses:							
Harris Fld	EPICON	EPICON	2.2%	4.5%	NA	4.5%	6.8%
Davis Park	EPICON	EPICON	0	0	NA	16.7%	0
Campbell	EPICON	EPICON	EPICON	2.0%	NA	2.6%	1.8%
DMATs	3.5%	9.0%	9.8%	4.8%	4.2%	2.3%	0
Deering Hosp	0	0	NA	5.3%	0	0	0
Baptist Hosp	2.0%	0.6%	1.1%	0	1.0%	NA	NA
2. Diarrheal Illnesses:							
Harris Fld	EPICON	EPICON	0	13.6%	NA	9.1%	0
Davis Park	EPICON	EPICON	0	0	NA	16.7%	21.4%
Campbell	EPICON	EPICON	EPICON	10.2%	NA	2.6%	1.8%
DMATs	2.8%	6.8%	4.9%	1.9%	2.8%	2.3%	3.6%
Deering Hosp	0	0	NA	0	0	3.8%	0
Baptist Hosp	15.3%	12.8%	10.9%	11.1%	11.2%	NA	NA

NOTE:
- No localized outbreaks of respiratory or diarrheal disease noted
- Increase in diarrhea at Davis Park over weekend, no common source, being monitored by LCDR Slaton, USN & USPHS
- One possible case of measles at Campbell site (2 mo. old)
- Two cases of measles at Homestead MS; mass immunization by DHRS

Epidemiologic Disease Surveillance Data
15 - 21 Sept 92
Military MTFs (17,885 visits for 8/30-9/21)
15 Reporting Nodes

No. Visits Monitored	667	839	583	547	515	309	509
Diagnostic Category	9/15	9/16	9/17	9/18	9/19	9/20	9/21
1. Minor Wounds	17%	14%	13%	14%	12%	11%	10%
2. Dermatologic	11%	10%	10%	12%	12%	11%	15%
3. Orthopedic Inj.	12%	14%	17%	14%	14%	19%	19%
4. Respiratory	10%	11%	9%	12%	12%	14%	10%
5. Gastrointestinal	5%	3%	6%	6%	3%	5%	3%
Diarrhea proportion→	1.8%	1.1%	2.0%	0.5%	0.8%	1.6%	0.8%
6. Dental	2%	3%	7%	4%	6%	7%	4%
7. Heat Inj. (No.)	0.6% (4)	0.9% (6)	0.9% (5)	0.5% (3)	1.4% (7)	2.3% (7)	1.2% (6)
8. Burn Inj. (No.)	1.0% (7)	1.1% (7)	0.3% (2)	1.5% (8)	0.8% (4)	0.6% (2)	0
9. Psychiatry (No.)	0	0	0	0.9% (5)	0	0.3% (1)	0.2% (1)
10. Animal Bites (No.)	0.9% (6)	0.5 (3)	0.2% (1)	0	0.2% (1)	1.0% (3)	0.2% (1)
11. Immunizations (No.)	3.1% (21)	5.2% (33)	3.8% (22)	4.6% (25)	5.4% (28)	2.3% (7)	2.4% (12)

NOTE:
1. AD Visits: 45% on 9/18; 48% on 9/19; 65% on 9/20; 63% on 9/21
2. Increase in dermatologic dx's for 82nd ABN Div (40% of AD visits on 9/21)
3. Cluster of cases of dermatologic illnesses in 82nd ABN Div,survey done on 35 cases on 9/22; probably occupational source

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

Preventive Medicine

Observation:

That an initial assessment of the situation by a multidisciplinary public health/preventive medicine (PM/PH) team would have been useful in developing a PM/PH plan.

Discussion:

Immediately after alert for disaster assistance deployment a Preventive Medicine-Public Health (PM/PH) team should be deployed to perform an initial assessment of the PM/PH aspects of the disaster area. Ideally, this team should be composed of subject matter experts in the areas listed below. The team need not be a new TOE team and need not be assigned at a particular post. The team should be a standing team with clear understanding that they are deployable within 24 hours to any site.

The following is a suggested team composition:

- Team Chief: 0-6 60-C (PM/PH physician)
- Epidemiologist: 0-4/5 60-C
- Entomologist
- Sanitary Engineer
- Community Health Nurse
- Veterinarian
- Civil Affairs Officer
- *Solid Waste Specialist
- *Water System Specialist
- *Occupational Health/Toxicologist

*Dependent on type and severity of disaster

The mission of the PM/PH Team would be to perform an initial assessment of the disaster situation. The assessment should focus on the following areas:

- availability and condition of:
  - food/food distribution system
  - water/water systems
  - shelter
  - sanitation facilities
- solid waste burden/handling facilities
- status of public health infrastructure
- health care facilities/staffing
- presence or absence of effective surveillance system

The team should seek access to predisaster data on:

- population demographics
- public health status
- health care delivery system

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

The team should establish contact with and identify POC's in the following areas:

state and local public health agencies
state and local medical professional societies
hospital associations
city, state and county leaders
water, solid waste, vector control agencies

After the initial assessment the team should provide the medical task force commander a specific listing of PM/PH assets required within the AO and a suggested timeline for their deployment.

The team will require priority transportation to the AO and within the AO. An initial aerial survey will be required upon arrival. The team will also require communications support. The team should deploy with portable computers and accessories. The team must be colocated with other deployed elements for logistical support. It should be located in close proximity to the disaster area rather than in the administrative rear areas.

The civil affairs member of the team would be responsible for developing an action plan for producing and distributing public health information. This officer would also be responsible for assessing cultural and linquistic issues in the disaster area.

At the discretion of the Medical Task Force Commander the PM/PH assessment team could be augmented with a clinician to assist in the over-all medical assessment specifically with the emergency medicine and primary care assessments. Ideally,the PM/PH team leader should have a firm background in clinical medicine thus obviating the need for an additional clinician augmentee.

Recommendation:

That a PM/PH initial disaster assessment team be developed between Forces Command and Health Services Command with the organization and mission described above.

Preventive Medicine

Observation:

That the decision to deploy an LX ento and an LX sani team early in the operation was crucial to the success of the PM/PH mission.

Discussion:

Most disaster scenarios will require sanitation and entomological support. An LX (ento) and an LX (sani) team should be alerted immediately and deployed early. The alert and deployment of these teams should NOT wait upon the initial assessment by the PM/PH Team. The literature supports the early need for entomological and sanitation support for most disaster scenarios.

Recommendation:

That an LX Sani and an LX Ento team be part of the initial lift for disaster operations.

Observation:

That the essential elements of analysis necessary to analyze the situation and to develop a PM/PH plan had to be identified as the operation progressed.

Discussion:

In future disaster exercises certain data will need to be obtained rapidly in order to facilitate analysis of the situation and to assist in developing a PM/PH plan.

The following information is required in order to determine the mission, the METL's, the task force organization and the task organization. The information is also required for evaluation of progress in return to predisaster levels of care.

- census track data on population demographics, socioeconomic status, and ethnicity
- health status indicators from local or national sources e.g. immunization coverage, TB rates, maternal-child health data
- medical care utilization data e.g.hospitalization statistics, emergency room visits, ambulatory care data, EMS calls, nursing home/special care home data
- endemic disease data from public health surveillance systems

The following data is required to assess the impact of the disaster:

- demographic data e.g. population shifts secondary to the disaster
- status of housing, transportation, and communications
- medical care utilization post disaster.
- status of medical and public health facilities
- status of water, sewer, and solid waste systems
- adequacy of water,food,shelter and medical supplies

Recommendation:

That the above listed information be considered essential elaments of analysis for future PM/PH operations in a disaster situation.

Preventive Medicine

Observation:

That the quality and provision of potable water was a major success in this operation and contributed to the absence of outbreaks of enteric diseases.

Discussion:

The provision of potable water is a primary public health concern in a disaster scenario. The status of the water systems in the AO is one of the Critical Elements of Analysis. The presence of a water sytems engineer from the Army Environmental Hygiene Agency was extremely helpful in coordinating JTF efforts with those of the civilian agencies. The presence of such an engineer should be doctrinal.

PM/PH personnel must be sensitive to political agendas which often spill over into the water system arena. In this case repeated positive samples from one water sytem led to our water surveillance team being asked to cease sampling in the area and turn over all sampling to thier civilian counterparts.

As was done in this exercise the sanitation teams must develop a plan for surveillance which is developed in conjunction with and approved by the local authorities. As was also the case in this exercise the sanitation teams must contact the state or local water testing laboratory to ensure that our water sampling techniques are approved by the lab. If the local lab prefers testing of a differnt type than ours the lab can instruct and certify our personnel in their specific methods.

Large quantities of bottled water were shipped into the AO early on. In many cases these containers set outside in the hot sun for several weeks. Many containers were found to be positive for coliforms when tested 18-20 days into the exercise. Doctrine for storage and expiration of bottled water supplies should be developed.

A central recieving and distribution point for donated and contracted water should be established immediately. This will facilitate water testing and will allow more efficient and timely distribution of water. It will also allow for a system of "first in... first out" to be instituted.

A decision was made to not recommend individual water purification instructions to the civilian populace. Boiling water was the only individual water purification technique recommended. This was based on the adequate supply of bottled water in the AO and the concern regarding the possibility of children obtaining chlorox, iodine, or halazone tablets if these methods of water purification were recommended. There was also concerned about the language issue and the literacy issue and the possibility that these chemicals might be used incorrectly.

Recommendation:

That water quality be assessed immediately in future operations. That a comprehensive water quality program covering municipal systems, community well systems, and bottled water be initiated as soon as possible in disaster operations.

That a water systems engineer be available for future operations.

Observation:

That adequate numbers and prompt cleaning of toilets was a major problem early in the operation.

Discussion:

Lack of toilets and failure of the contractors to keep toilets clean was a significant problem in the early part of the deployment. The problem was addressed by reworking the contract by DFO. The solution included requiring all contractors to clean any toilet they found at any site. A central control point was also established at DFO level to facilitate requests for additional toilets and for requests for cleaning.

The final contract used in this operation should be used as a template for future contracts. A central point for managing toilet issues should be established as was done in this operation. Consideration should be given to procuring and stockpiling personal toilets such as the one described in Appendix 1 which could be rapidly transported in large quantities and used until portable toilets become available in sufficient numbers.

Recommendation:

That the contract for toilets developed in this operation be used as a template for future operations.

That consideration be given to stockpiling individual disposable toilets for future operations.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

Preventive Medicine

Observation:

That the solid waste problem in this operation was staggering.

Discussion:

The massive amount of solid waste generated by the disaster quicky overwhelmed the local solid waste management systems. The environment of south Florida interfered with several of the more comman solid waste management techniques. Burial of the waste was not possible in south Florida due to the high water table and the underlying limestone formations.

The final contracts which led to the successful management of the solid waste burden should be used as a template for future operations. This contract should be let immediately after the initial assessment and be among the highest priorities for funding.

The accumulation of solid waste and household garbage are major public health issues. The accumulation leads to fly and rodent problems which in turn increase the risk of vector borne diseases.

The ability to augment the PM/PH assets with a solid waste expert from the Army Environmental Hygiene Agency (AEHA) was crucial to the accomplishment of the mission. In future disaster operations early augmentation with a solid waste expert should be considered. Expertise from AEHA may also be required in the area of air pollution should large quantities of solid waste need to be burned and local/state/federal air quality experts are not available.

Recommendation:

That the final solid waste contract implemented in this operation be used as a template for future operations.

That a solid waste expert be readily available for future operations.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

Preventive Medicine

Observation:

That vector survey and control issues were extremely important issue in this deployment and could have had major negative public health impact had it not been addressed quickly and professionally.

Discussion:

Entomological issues were extermely important in this operation due to the south Florida environment and the large quantities of decomposing food and organic matter in the devastated areas. The mosquito problem which is a perenial problem in south Florida was complicated in this case by the large number of persons without adequate shelter who were at risk for bites. The problem was further complicated by the slight risk of encephalitis which had been a problem in north Florida for the past several years.

The coalition developed to address this problem in this operation is a model for future operations. The coalition included entomologists from CDC, USAF Reserve Aerial Spray Teams, local mosquito control personnel, Army preventive medicine and US Public Health Service personnel, and US Navy Disease Vector Control teams. The state contract with a major pest control company provided sorely needed manpower for pest control and should be used as a template for future contracts. t.

Recommendation:

The pest control contract should be used as a template for future disaster assistance operations.

PATIENT ADMINSTRATION

OBSERVATION:

Who is eligible for care as part of the disaster relief operation?

DISCUSSION:

The mission statement for the Joint Medical Task Force is "Provide basic medical support on an area basis to civilian community in conjunction with Disaster Relief Operations until the civilian healthcare infrastructure has been reestablished and predisaster levels of health support is available." The concept statement reads "Uniformed medical services, in conjunction with local, state, and federal medical resources, provide primary and secondary healthcare and medical surveillance within the federally declared disaster area."

It is our interpretation that this mission statement allows members of the medical contingent to treat all victims of the disaster, as well as all categories of personnel involved in the relief effort, including volunteers, contract workers, other federal employees, Red Cross workers, members of county, state and federal relief agencies, and other personnel contributing to the relief effort. The Joint Task Force Surgeon has broad authority within the mission statement to treat almost any category of patient who asks for care or is discovered to have a medical problem.

POC: COL McLain or Ms. Hanson, 756-0102.

PATIENT ADMINSTRATION

OBSERVATION:

As the disaster relief operation draws down, and certain areas are deemed restored, who can receive care, and under what circumstances? Included in this question are volunteers, contractors, federal employees of other agencies, Red Cross workers, and members of county, state, and federal relief agencies.

DISCUSSION:

The mission statement, in part, reads "...until the civilian healthcare infrastructure has been reestablished..."

Decisions to disengage will undoubtedly be made on an area by area basis, when local and state officials determine that a predisaster level of civilian health service has been restored. These decisions will be made in conjunction with local military commander; the military presence will be withdrawn as "sub-areas" are determined to be restored. It is our interpretation that when an area has been declared restored, the basic rules of eligibility stated in AR 40-3 should be followed. For many categories of personnel, this means that the military would no longer be the primary source of care. In principle, a military medical unit in such an area would be bound by the same rules of eligibility that govern access to our peacetime fixed facilities. We can continue to provide emergency care to any patient, but we would no longer be the source of primary care for most patient categories. There is no further legal or regulatory basis for providing area primary care to non-beneficiaries, after civilian health services have been restored.

POC: COL McLain or Ms. Hanson, 756-0102.

PATIENT ADMINSTRATION

OBSERVATION:

Tripler Army Medical Center (TAMC) personnel were asked if TAMC could provide shelter/care for nursing home patients whose home had been heavily damaged.

DISCUSSION:

This request seems to be reasonable, and within the scope of the local commander's authority. Our concerns are:

1. There should be a finite time limit to our acceptance of the patients (30 days?).
2. The patients should be in a pay status. Patients who are indigent should be handled in accordance with guidance published in HSC Bulletin 3-89, page 14.
3. There should be no perceived degradation of service to our beneficiaries as a result of accepting this mission.
4. The legal issue of accepting patients for domiciliary care should perhaps be addressed by the HSC JAG.
5. TAMC should not be viewed by local nursing homes as a competitor for these patients.

POC: COL McLain or Ms. Hanson, 756-0102.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

MEDICAL LOGISTICS

OBSERVATION:

Information necessary to keep the Army leadership informed of status and issues was difficult to obtain during the first several days of the relief operation.

DISCUSSION:

During the initial phase of operations, there is a substantial need for information by DA Staff to keep the leadership informed. This is precisely the time that information is most difficult to obtain due to the confusion in the AOR, a probable lack of communications capability (communications infrastructure damaged or destroyed) and a primary focus toward mission accomplishment.

RECOMMENDATION:

A liaison team, composed of representatives of ops, log, PAD, and professional services, be dispatched to the scene with the primary focus of collecting information and passing it to DA Staff.

POC: MAJ Daley, DASG-HCL, 756-8062.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

MEDICAL LOGISITICS

OBSERVATION: Identification of Medical Materiel Without National Stock Numbers. Medical supply personnel require a means to identify materiel received without an NSN. This is essential for inventory control, warehousing, and issuing of materiel. Manual methodologies are available to do this, however, they are time consuming and labor intensive.

DISCUSSION: Large quantities of medical materiel were donated to the relief effort. Since this materiel came from vendors, NSNs were not marked on the materiel. Manual methodologies are available for item identification, however, they are time consuming and labor intensive. Use of CD ROM readers and a PC to access data in FEDLOG and MED CAT catalogs is the preferred method.

RECOMMENDATION: Units should deploy with a CD ROM reader, PC, and appropriate CD catalogs to enable item identification. PCs and CD ROM readers will be authorized to units in the next CTA 50-909 Update.

POC: MAJ Daley, DASG-HCL, 756-8062.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

MEDICAL LOGISTICS

OBSERVATION:

Department of Defense Activity Address Code (DODAAC). The 32nd Medical Logistics Battalion did not have a local DODAAC established at either Opa-Locka, or Homestead Air Force Base. A local DODAAC would have made it easier for the unit to receive supplies directly from the wholesale supply system instead of through its parent organization at Ft. Bragg.

DISCUSSION:

Prior to deployment units should request a new DODAAC, or, or the addition of a supplementary address to the existing DODAAC. A more responsive system must be developed to allow a deployed unit to quickly obtain a new or revised address code. This issue also surfaced during Operation Desert Storm. Corrective action is being addressed through the Total Distribution Action Plan.

RECOMMENDATION:

Request designation of OTSG as a Coordinating Agency for TDAP issue 22.0, Lack of Timely Changes to the Address File, from DA, DCSLOG. The OTSG will then be able to monitor progress in resolution of the issue and comment on the action as required.

POC: LTC Touchton, DASG-HCL, 756-8062.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

MEDICAL LOGISTICS

OBSERVATION:

Medical Logistics Support of Civilian Agencies Involved in Disaster Relief Efforts. In supporting civilian health service support (HSS) agencies involved in disaster relief efforts, the following were found to be critical to success:

a. Formulary, or other means of limiting the number of items ordered.

b. A central agency , or agencies, to receive, validate and forward requests from civilian HSS activities to the supporting Medical Logistics Battalion (MEDLOG BN).

DISCUSSION:

The above are necessary to keep the number of items that the MEDLOG BN must order, receive, maintain, and issue to a manageable level. Otherwise, due to the variety of health care providers at each activity, an almost limitless number of items could be ordered. A characteristic of disaster relief efforts, such as that for Andrew, is that health care organizations are activated, moved, and deactivated on a frequent basis as req-uirements are better defined. It is, therefore, necessary to have requests validated by someone familiar with each activity's mission, workload, as well as activations and deactivations.

RECOMMENDATIONS:

Document this finding for future reference.

POC: LTC Touchton, DASG-HCL, 756-8062.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

MEDICAL LOGISTICS

OBSERVATION:

Assignment of a Pharmacist to Medical Logistics Battalions (MEDLOG BNs) Involved in Disaster Relief Efforts. Despite establishment of a formulary, civilian health service support (HSS) activities involved in disaster relief efforts often order non formulary items. Normally, it would be appropriate to reject such requisitions. Based on the fact, however, that donations on hand from various sources might well provide generic, or therapeutic equivalents to the requested item; it is desirable to have a pharmacist available who can screen requests against the items on hand to identify viable substitutes. Also, the donated materiel might well provide satisfactory substitutes for out of stock formulary items.

RECOMMENDATION:

That a pharmacist accompany each MEDLOG BN deployed in support of disaster relief efforts.

POC: LTC Touchton, DASG-HCL. 756-8062.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH FACILITIES

OBSERVATION: Scope of Health Facility Assessments. Health facility assessment must encompass all health care delivery sites/structures to include hospitals, clinics, speciality care sites, physician office-clinics, nursing homes and other in-patient facilities.

DISCUSSION: When assessing total health care delivery for an area, all health care sites must be included, especially those outide the more obvious hospitals and large health clinics. For example, in a medium-sized community there will be some number of specialty clinics (i.e., renal dialysis, outpatient surgery), dental clinics, physician office-clinics and other in-patient facilities such as psychiatric group homes and nursing homes. Each of these smaller medical units produces some number of daily clinic visits and/or in-patient care for the local populace. In the case of physician office-clinics, the outpatient care provided by 100 doctors can easily exceed that of the local hospital (30-40 outpatient visit/day/physician equal 3000-4000 daily patient contact). Similarly, the number of nursing home beds can also exceed the number of acute care hospital beds in a community. Incorporating all these various health care delivery sites is crucial to managing emergency operations, as well as long-term recovery.

RECOMMENDATION: That Army planners and Health Facilities Assessment and Assistance teams include all types of health care delivery facilities in their mission statement.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH FACILITIES

OBSERVATION: Health Facilities Assessment and Assistance (HFAA) Team Act as a Coordinating Element for Civilian Agencies. It would be beneficial to have the HFAA team act as a general coordinating element in assisting state and local officials in prioritizing and monitoring the return of public utility services, issuance of building permits and allocation of construction resources.

DISCUSSION: Due to the numbers and types of health care facilities located within most civilian communities, local and state authorities are faced with a monumental prioritization and coordination responsibility. In order to expedite damage repair for the facilities, all aspects of building design and construction must be managed, to include prioritizing: the allocation of portable generators and communications systems; the efforts of public utility repair crews (electrical, telephone, water, trash); the inspection for and issuance of building permits and the emergency management of construction assets and building materials.

RECOMMENDATION: In those instances where the military has been tasked with operation command and control, suggest the Health Facilities Assessment and Assistance teams act as the coordinating element for prioritizing the rebuilding effort in the arena of health care delivery.

MEDICAL OBSERVATION FROM HURRICANE SUPPORT OPERATIONS

Patient Adminstration

Observation:

Reporting of patient visits was not standard throughout the task force, therefore accurate and timely statistics were not available from a centralized source.

Discusssion:

Individual units from all services arrived in the area of operation with a variety of field SOPs depicting a variety of contingency oriented reporting requirements. Differing data to be reported were reported as of different report cut-off times and different due times. Data identified of command interest for a natural disaster situation differed from that of a normal contingency operation. Coordinating a common required set of data, to include reporting periods and report due times, between the services/units of the entire task force proved difficult at best. Complicating the issue was an implied individual service requirement for separate reporting of statistics as "back channel." Duplicate reporting channels for some units and duplication of statistical manipulation of various JTF levels of command resulted in confusion of who had the accurate figures at any given point in time. Civilian agencies and non-uniformed federal agencies requested statistics from their uniformed counter parts. Conclusions drawn from these statistics could only be as good as the accuracy and timeliness of the source level of the chain of command. Some units reported diagnosis required statistics (center for disease control and preventive medicine related) accurately, while others did not. Source documents at the unit level for the statistics varied, and were not always accurately completed. (Note: Field Operating Epidemiologists and Preventive Medicine Teams more accurately collected such data through personal interviews of reporting units and field observation.) The one commonality of reporting was the operating definition of a patient visit, which was a "patient contact." Figures reported have been accurately tabulated. The accuracy of the figures themselves are dependent on the operating procedure of each individual unit.

Recommendation:

A standard set of data of statistical/epidemiological value needs to be established for use in conjunction with natural disasters. For which a collection methodology can be standardized within DOD. A recommended report cut-off is 2400 hours to coincide with standard hospital inpatient report periods. Which would be included in standard reports (inpatient data). Due times can be established IAW senior command needs, but should allow for at least subordinate command elements to tabulate. All this must be standardized across service participants in a task force.

POC is LIC Gardner, DSN 236-4684.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

READINESS

OBSERVATION:

The Surgeon Generals' Readiness Division provided a listing of Army medical assets (compo 1,2 & 3) in the affected area and a determination of their readiness status.

DISCUSSION:

Since most Reserve Component hospitals only have a Mission Essential Equipment for Training (MEET) set, they are totally unprepared to respond to disasters in even a partial manner. Furthermore, with the downsizing of the National Guard, the greatly reduced state of military hospital assets will exacerbate the problem. Additionally, the ability to simply input a geographic area and have a display of the DoD medical assets within a specfic radius would be beneficial.

RECOMMENDATION:

The Reserve Medial Manpower Information System (REMMIS) be expanded to include all DoD assets for all components. All MEET sets be expanded to at least make the set fully supportive within the maintenance and storage capabilities of parent units. Some of the USAR hospitals be converted to Guard assets to ensure broader availability of medical support.

POC: LTC Kremenak, SGPS-HCR-X, 756-8050.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH CARE OPERATIONS

OBSERVATION:

Due to the time senstitive reports and briefing requirements, DASG had to bypass CINCFOR for information.

DISCUSSION:

During the early stages of deployments to South Florida, OTSG was tracking the number and type of units deployed. After several conversations with the Joint Task Force Surgeon and CINCFOR Surgeon there were units deployed that CINCFOR was unaware of. After many requests, extensive delays and critical time lines, DASG went directly to the Joint Task Force for information. Secondly there was a lack of information on what the sister services were providing.

RECOMMENDATION:

CINCFOR Surgeon be more responsive to time senstitive data required and staff may need to be augmented. Constant review of TPFD and track deployments.

POC: MAJ Lemon, DASG-HCO, 756-8186.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH CARE OPERATIONS

OBSERVATION:

Patient accounting procedures and validity.

DISCUSSION:

From the onset of DOD support, it was only when DASG called the JTF Surgeon to inquire of patient accounting that they began to develop the patient accounting procedures/systems. Finally, on 6 Sept 92, the first patient census was provided in the JTF Andrew sitrep.

RECOMMENDATION:

A common patient accounting and tracking system is available in the standard DOD TAMMIS systems. This system is used throughout the military but was not used in this operation. Joint Task Forces should be equipped and used the TAMMIS systems.

POC: MAJ Lemon, DASG-HCO, 756-8186.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH CARE OPERATIONS

OBSERVATION:
Medical Professional Filler System (PROFIS) worked well.

DISCUSSION:
PROFIS was activated early into the operation. Rosters and POR records were current and personnel deployed on time. PROFIS was also activated to backfill FT Bragg and FT Devens.

RECOMMENDATION:
None

POC: MAJ Lemon, DASG-HCO, 756-8186.

MEDICAL OBSERVATIONS FROM HURRICANE SUPPORT OPERATIONS

HEALTH CARE OPERATIONS

OBSERVATION:
FLY AWAY KITS

DISCUSSION:
When the AOC is activated, DASG-HCO-P moves to the AOC. REsources are limityed especially after duty hours. Items such as palnning data, BOA's etc are not available. Space in the AOC is a limiting factor.

RECOMMENDATION:
Develop a fly away kit that will serve both the AOC and the EOT. Kits should be on floppy disks such as the OTSG Phone book etc.. Manuals should be stocked.

POC: MAJ Lemon, DASG-HCO, 756-8186.

1. (U) JULLS NUMBER: ~~02160-00400(00001)~~, submitted by OASD(HA), COL WH DICE, 227-8233, (703)697-8233.

2. (U) JTF ANDREW conducted on 10/23/92

3. (U) KEYWORDS: None.

4. (U) TITLE: Disaster Medical Assistance Teams require sustainment support

5. (U) OBSERVATION: National Disaster Medical System (NDMS) Disaster Medical Assistance Teams (DMAT) are not self sufficient. DMAT require other agencies to provide food, water, shelter, power, fuel, lights, refrigeration, transportation, security, waste disposal, and medical supplies.

6. (U) DISCUSSION: DMAT are groups of amateur volunteers with variable medical credentials including physicians, nurses, allied health personnel, emergency medical technicians, and first aid personnel. The NDMS through the US Public Health Service administers the DMAT program. The USPHS has enrolled over 2000 people into DMAT nationwide. DMAT are left to their own devices for equipment and training. DMAT generally obtain equipment scavanged from excess military supplies or from community donations. The USPHS does not require DMAT to validate their capabilities and does not require regular exercises. During activation DMAT are "Federalized" for reimbursement and liability purposes.

Hurricane Andrew destroyed the medical infrastructure in south Dade County. When NDMS was activated under Emergency Support Function #8 of the Federal Response Plan, DMAT were deployed into the area. The lack of standard equipment and objectives created unique support problems for each DMAT. Support for DMAT was diverted from other resources and required excessive oversight because DMAT were rotated every 5 to 7 days.

No organic transportation is available for DMAT. DMAT require transportation for equipment and personnel in and around the disaster area. Transportation is required to move patients to and from the DMAT. Transportation was arranged from rental agencies, US Coast Guard, and Metro Dade Fire Rescue (personnel) and from the military (equipment).

DMAT do not carry fuel for generators. DMAT are not required to maintain their own generators. DMAT cannot function without power for medical equipment and lights. DMAT do not carry light sets capable of supporting medical operations. Generator support was required as well as fuel support. Generators were obtained from several sources coordinated through the Disaster Field Office. Fuel contracts with local

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suppliers were used. However, the small fuel storage capacity at each site and the high demand in the area led to power failures.

Nonstandard medical equipment and supplies are the rule for DMAT. DMAT expended their basic load within 24 to 36 hours. Since DMAT carry nonstandard supplies, DMAT were required to adapt to the Federal supply system and use unfamiliar medications and other expendable medical supplies. DMAT did not have prepared supply lists and were not prepared to estimate supply requirements. DMAT expected to practice with the same supplies available in a nondisaster environment and were not prepared to deliver medical care in an austere setting. In several instances, DMAT required stress debriefing because the disaster setting required them to deliver care without the usual quality assurance guarantees of routine hospital practice. DMAT expendable supplies were obtained directly through the local Department of Veterans Affairs hospital and indirectly through the NDMS Operations Center which contacted FORSCOM and Second Army for emergency resupply. The 32 MEDSOM became the DMAT supply point when it arrived. Durable DMAT equipment excluded xray, refrigeration, and laboratory. Hundreds of casualties required transportation to facilities north of the disaster area for xrays or laboratory support. Other durable equipment required exchange when arriving DMAT replaced departing DMAT. Biological medications including immunizations required refrigeration. Neither refrigeration nor ice was available initially, but was provided through contractors or local purchase within days. Since electronic medical equipment has unique brand name accessories, each DMAT required its own particular durable equipment support package.

DMAT do not deploy with organic food or water. An emergency request for Meals-Ready to Eat ensured DMAT were fed until local contract vendors were in place to support the relief workers. Water was initially obtained from the National Guard. An emergency request for bottled water was filled by DoD. DMAT do not have water testing capability. DMAT water requirements for patient care (wound care) could only be met by emergency supplies from the DVA and DoD.

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DMAT physical security requirements were greater than expect ed. DMAT personnel at a site colocated with a police and fire staging facility demanded security enhancements that eventually included diversion of an infantry platoon from neighborhood patrol to perimeter duty for the DMAT. The perceived threat of violence from patients and displaced persons caused the DMAT security requirements. In addition, DMAT could not function effectively without controlled access to the patient care area since bystanders and volunteers disrupted internal communications and obstructed patient care.

The high volume DMAT operations generated medical and nonmedical waste requiring disposal. DMAT carried insufficient containers for used needles and biological waste. Biological waste disposal was eventually contracted. However, waste removal at some sites was delayed for weeks. Disposition of bodies from DMAT was not considered by DMAT prior to deployment. County Medical Examiners were contacted and authorized DMAT to hold bodies until transportation was available. Refrigerated trucks were used to store bodies until they could be moved to a functioning morgue.

DMAT were limited to operating out of fixed facilities. Although several of the DMAT included organic tentage, DMAT are not prepared for extended operations under tents. DMAT do not have site preparation equipment and require engineer support. DMAT endurance is short so site turnover was frequent. Since DMAT tents belong to the DMAT, the tents could not be left in place for follow-on DMAT to use. It is unlikely that DMAT can operate successfully out of organic tentage unless DMAT endurance can be extended and engineer support is available.

7. (U) LESSON LEARNED: Anticipate immediate Class VIII supply requests, fuel, and transportation when DMAT are employed. Be prepared to provide 10KW generator support including maintenance personnel and electricians. DMAT produce biological waste that requires special handling and disposal. Be prepared to provide food, water, sanitation support, and security when DMAT are employed. DMAT provide personnel consistant with level 1 and 2 support without xray or laboratory.

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3. (U) KEYWORDS: None.

4. (U) TITLE: Disaster Medical Assistance Teams require sustainment support

8. (U) RECOMMENDED ACTION: Establish a support unit designed to provide the base support required for volunteer medical teams during deployment. The NDMS Senior Policy Group should address the concept of staffing and funding regional support packages. Personnel for the support unit should be professionals from the USPHS, DoD, and DVA, who are exercised and familiar with the equipment.

9. (U) COMMENT: DMAT personnel are well motivated volunteers who expect to deliver medical care in the field based on their civilian experience. DMAT have no unifying command and control structure and do not have standard equipment or operating procedures. DMAT are best thought of as a personnel pool available to professionals trained in disaster response. Current NDMS DMAT "doctrine" is to use a DMAT as a team with its own command and control. The Florida DMAT experience showed that DMAT personnel are well trained individuals, but that DMAT are amateur organizations requiring professional supervision to function in the chaos of a large scale disaster. DMAT should be thought of a national personnel resource that provides task organized individuals to a national command and control organization able to provide base support. The concept of DMAT as well organized response teams was invalidated during the response to Hurricane Andrew.

1. (U) JULLS NUMBER: ~~02443-67100(00002),~~ submitted by OASD(HA), COL WH DICE, 227-8233, (703)697-8233.

2. (U) JTF ANDREW conducted on 10/23/92

3. (U) KEYWORDS: None.

4. (U) TITLE: Disaster Medical Assistance Teams lack command and control

5. (U) OBSERVATION: Disaster Medical Assistance Teams (DMAT) leaders are not trained or prepared for disaster response operations. DMAT "commanders" responding to Florida after Hurricane Andrew had never exercised in a multiagency environment and had no experience in large scale Federal response operations. The amateur command and control of DMAT led to uncoordinated support requests and direct competition between DMAT and other responders for scarce resources. Although DMAT are a Federalized asset of the National Disaster Medical System (NDMS), NDMS was unable to control the deployment, employment and redeployment of DMAT because DMAT personnel refused direction from the NDMS leadership.

6. (U) DISCUSSION: DMAT are "commanded" by community organizers who recruit personnel and solicit community support. NDMS does not require any special qualifications or training for "commanders." NDMS does not provide DMAT with required exercises or training to prepare them for integration into the Federal response. DMAT serve many masters. Local communities, counties, states, and international agencies use DMAT in their plans and operations. The NDMS mission for DMAT is diluted by the other organizations.

During relief operations for Hurricane Andrew, DMAT "commanders" insisted on maintaining DMAT integrity rather than task organizing the personnel. Requests for DMAT personnel to provide service with other response organizations were refused. DMAT "commanders" ignored established communications through the NDMS structure. In spite of an established chain of command between DMAT and NDMS, DMAT "commanders" refused to report through the chain or make support requests through the chain. One DMAT, 24 hours after arriving, notified NDMS of its redeployment after many of its personnel had departed. Another DMAT refused to rotate its personnel and because of fatigue requested redeployment within 4 days of arrival. The same DMAT refused to allow NDMS to make redeployment transportation arrangements and contracted buses and aircraft without coordination for a replacement. Still another DMAT made direct contact with their State Air National Guard and attempted to arrange flights for its redeployment without

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3. (U) KEYWORDS: None.

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coordinating through NDMS. A fourth DMAT commandeered scarce medical equipment and supplies without coordination with ESF #8.

DMAT "commanders" also failed to provide enough leadership to establish discipline within their organizations. One DMAT held a redeployment party that seriously jeopardized the credibility of the entire medical response. Another DMAT openly antagonized the medical staff of the clinic being used by the DMAT. Several DMAT "commanders" permitted consumption of alcohol during the deployment.

Several DMAT refused to deploy after being alerted by NDMS. Reasons given by "commanders" included lack of available personnel, a preference for conflicting nondisaster related acitivites, and a perception that the DMAT would not be employed . On the other hand, one DMAT "commander" deployed the DMAT without coordination with NDMS. Another "commander" commandeered a press airplane to enhance the chances the DMAT would be deployed.

7. (U) LESSON LEARNED: DMAT cannot be trusted to deploy when directed, perform missions as directed, or stay on station until relieved. DMAT commanders are unqualified and should be considered ineffective until proven otherwise. Individual DMAT personnel are effective and attempts should be made to task organize personnel into response teams under NDMS command and control.

8. (U) RECOMMENDED ACTION: NDMS should restructure the personnel enrolled in DMAT into a national register of disaster response personnel. DMAT organizations should be directed at enrolling personnel and maintaining records. NDMS should build a national response command and control cadre from DoD, DVA, and USPHS assets capable of incorporating enrolled DMAT personnel when called to Federal duty. DMAT personnel should receive basic disaster response training upon enrollment and sustainment training twice a year. NDMS sustainment exercises should include command and control, support, and DMAT personnel.

9. (U) COMMENT: Although DMAT command and control is addressed in this lesson learned, NDMS has not established any standard

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equipment for DMAT or developed a exercise and validation program for DMAT. Amateur volunteers can never be relied upon to provide the spearhead for a Federal response after a crisis. Volunteers without equipment or standardized training cannot be expected to work effectively within a multiagency response. The NDMS concept for DMAT has been tried and failed. However, the concept of using volunteers in a disaster response is valid based on the performance of individual DMAT personnel in Florida. NDMS should continue identify dedicated qualified civilians and be prepared to call on volunteers in the Federal response.